

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7503	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2012
NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During complaint investigation of #30396 and #30564, conducted on October 22 - 23, 2012, at Mayfield Rehabilitation Center, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

D8XF11

If continuation sheet 1 of 1